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AUTHOR Wood, Barbara L.
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ABSTRACT

To defend against the instability and dishonesty of his family life, the child of an alcoholic parent may adopt the role of the hero--a highly conforming, highly achieving "good child" who seeks to redeem his family and himself through his accomplishments. Children of alcoholics adhere to their childhood roles as adults and may even create an adult environment that reinforces those roles. A family hero may choose to become a therapist working with chemically dependent or co-dependent clients. These heroic therapists often bring a great capacity for empathy to their work with chemically dependent individuals and families, and the therapists' will to restore can become the basis for hope, compassion, courage, and perseverance. However, this will to restore may also operate as a compulsive, destructive force. In order to accomplish the goals of therapy, therapists who are also family heroes must examine their own reactions to the emergence of deep feelings and contend with the will to restore, which may divert therapy from its beneficial course and reproduce the inhibiting conditions of the alcoholic home. (NRB)

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THE COA THERAPIST:
When The Family Hero Turns Pro

Barbara L. Wood, Ph.D
35 Wisconsin Circle
Suite 310
Chevy Chase, Maryland 20783

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INTRODUCTION

Good Morning. We have come together today to consider the special talents, and the particular limitations that a family hero may bring to psychotherapeutic work with chemically dependent or co-dependent individuals. This topic is one that is, I'm sure, of great personal, as well as professional, importance to many people in this room. Charles Whitfield has estimated that up to % of human service professionals may be the children of alcoholic parents. It is my belief that many, if not most, of these COA helpers are family heroes. Tempered, tested, and often still troubled by their own experiences with an alcoholic parent, they have made the restoration of dependent families a life-long mission: They have turned pro.

I am a family hero myself, and have supervised numerous other heroes who have chosen to turn pro. The effort to identify and understand the unique clinical phenomena that are likely to occur when an heroic therapist ministers to a chemically dependent client or to another co-dependent is one that has engaged and perplexed me for some years now. I am most pleased to have this opportunity to share some of my own thinking about it with you, and to solicit your ideas and observations as well.

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HOW THE HERO GREW

In order to understand the heroic therapist, we will have to review the forces and events that determine the quality of a child's life in an alcoholic family. If I were forced to limit myself to two adjectives in an effort to convey the flavor of life in an alcoholic home, I think I would select the terms "unstable" and "emotionally dishonest" as the most essential terms. In what ways is the alcoholic home an unstable one? First of all, a parent who is drinking heavily, or using any psychoactive drug to excess, is an unreliable parent. The chemical compulsion becomes the center of the parent's psychic existence, and commitments made to children, or to anyone else for that matter, begin to be quickly and repeatedly broken as they begin to intefere with opportunities to drink or drug. Secondly, the alcoholic home is unstable because the drinking parent is an unpredictable parent. Most importantly, he or she is <u>emotionally unpredictable</u>. One of my clients remembers very clearly a fishing trip with his father that began as a peaceful, companionable sort of outing for him and his father and mother. However, his father spent most of the afternoon drinking instead of fishing, and, as the day wore on, got into a terrible argument with his mother. My client intervened when he sensed that his father was about to take a swing at his mother. This enraged the father, who ran to his truck, grabbed his shotgun and began to threaten his son with it. Terrified, my client ran from the campsite, and spent the night huddled in a ditch, hiding from his father, who continued to stagger about in the brush, and to hunt him down, shotgun in hand,

throughout the night.

The alcoholic household is also unstable in the sense that the alcoholic and his/her family live in an atmosphere of chronic crisis. Due to the breakdown of logic, and the progressive loss of self-control, the alcoholic's affairs are never in order. She can't manage herself on the highway, on the job, or in the home, and life always seems as though it's about to completely unravel. The law's angry and wants to send her to jail, or the boss is angry and wants to fire her, or Dad's angry and wants to leave her. Maybe all three. These circumstances produce a constant and deep-seated anxiety for the chid, who feels that the life of the parent and the integrity of the family are ever at risk.

In what ways is the alcoholic household an emotionally dishonest one? Above all, it is dishonest because the central fact of everyone's existence and experience--the compulsive drinking--can not be faced, or even discussed. This is the conspiracy of silence, based on the need to deny the alcoholism and avoid the shame and fear that would attend it's acknowledgement, and it is the ultimate emotional dishonesty. This dishonesty broadens and deepens as the family, fearful of upsetting the dependent's shakey emotional applecart, or their own fragile self-esteem, supress or distort every real emotional reaction to the situation. However, suppression of the anxiety, shame, guilt, disappointment and rage only serves to intensify these feelings, and as they do grow more intense, they break through in explosive fashion from time to time. Thus the family moves back and forth from an atmosphere of intense, uncontrolled

expression of feelings, to an emotionally muted and falsely pacific state.

WHO IS THE HERO?

The child who lives in an alcoholic home must find a way to defend against the instability and dishonesty of family life. Sharon Wegscheider, and others, have pointed to the fact that many children cope by adopting certain "roles" which serve to bring some semblance of stability to family existence and to one's own psychological experience. These roles also to mask intense and painful emotions which, if openly expressed, might shatter one's self-esteem, as well as the fragile family structure. Wegscheider suggests that the most common childhood roles include that of the hero, the scapegoat, the lost child and the mascot.

We are concerned today with the hero--a highly conforming, highly achieving, "good child" who seeks to redeem the failing family, as well as to justify his or her own existence, through great accomplishments and noble deeds. Family therapists might also call this individual the "parental" child, the child who assumes, or is forced to assume, an inappropriate amount of responsibility for sibling, and for the household in general. The unconscious goal of the hero is to be <u>so</u> good, that the drinking parent will be filled with pride and good feelings, and thus be empowered or persuaded to stop drinking and to become a fully functioning member of the family once again. Since this end is actually beyond the hero's ability to effect, it is usually doomed to failure, and so is the hero. Therefore, this child, though he or she may indeed perform many other wonders, will always be haunted by the sense that nothing that has been accomplished is

truly satisfying, or really enough.

As the disease of alcoholism progresses, and the family situation deteriorates, the hero's options for change and growth are eroded. That is, the family's need for redemption and rescue deepens and the hero's identity becomes increasingly organized around the attempt to fulfill these needs. It seems to me, in fact, that the hero becomes as compulsively organized around the restoration of the family as the alcoholic is organized around the pursuit and use of alcohol. As Charles Deutsch says in Broken Bottles and Broken Dreams :

> The children in most trouble are from the outset so restricted and bound into their reactive roles that they become little more than their roles. Given over to an exaggerated and rigid identification of self with role, so protected by it and at least nominally rewarded for it, (they) have great difficulty operating outside it. (p.57)

A HERO FOR LIFE: "The Tragedy of Fate Neurosis"

Charles Deutsch notes that children of alcoholics adhere to their childhood roles as adults, and are so "merged" with these roles that they will create an adult environment that "requires and reinforces" the role. Deutsch's observation must recall to each of us the all too familiar example of the family hero who can only fall in with alcoholic chums and love partners, and who, after each grievous betrayal must keen anew: "But I didn't know he was a drunk at first!" Helene Deutsch (1930) wrote much earlier of the "fate neurosis", remarking upon the fact that some individuals seemed to encounter the same tragic problems no matter where they turned. While their suffering seemed, at first blush, to be imposed by unfortunate circumstances in the outer world,

Deustch thought the root of the problem might really be a "constant, insoluble, inner conflict" (p.) Recently, Leon Wurmser (1981) has attempted to clarify the motivation for the fate neurosis, and I think his words are instructive for those of us who must struggle with the hero's indomitable and sometimes self-destructive will to restore the alcoholic parent and the shattered family:

> The aim (is) not to find the good parent, the idealized one; it (is) to find the severely damaged and disappointing parent, toward whom all the anger and pain (are) still raging, and to repair and restore him, to wipe out his peculiar damage, to undo his specific disappointments--and the greater his shortcomings, the more exciting the hope of his restoration. (p. 170)

Wurmser finds in this unconscious, compulsive process a "deeper reciprocity": The hidden belief of the individual that if she can only heal the impaired loved one, she will also heal her own damaged and suffering self. Though this pattern is masochistic in the sense that there is a compulsive re-engagement with disappointing figures and punishing circumstances, the goal is not to enjoy the pain, but to accomplish and enjoy an eventual victory over past suffering.

THE HEROIC THERAPIST

If the will to restore is an important guiding priniciple in the life of the hero, it will doubtless emerge as a crucial factor in the attitudes and approaches that an heroic therapist brings to his/her professional functions. It is likely to be repeatedly evoked in those situations in which the therapist's work requires daily confrontations with the disease of alcoholism and its devestating effects on the family; and it should be especially powerful where the therapist's own life as a hero remains

essentially unexamined and the need to restore is unrecognized and thus, beyond conscious control. It is my experience that adult children of alcoholics often bring an extraordinary capacity for empathy to their work with chemically dependent individuals and families, and that the will to restore can become the basis for the very qualities of hope, compassion, courage and dogged perseverance that we consider to be so indispensable in our work. However, I also believe that in the heroic therapist, that is, the therapist whose role armor has not been pierced by self-analysis, supervision or psychotherapy, the will to restore often operates as a compulsive, destructive force. It is fueled, as Wurmser says by fear and flagging self-esteem, and may be ill-informed and insensitive as to its effects on others, including clients.

THE WILL TO RESTORE:
Clinical Ramifications

What behavioral phenomena and clinical outcomes are associated with the will to restore? In my experience, the will to restore most manifests itself in several ways, including an impatient "rush to recovery" by the therapist treating the chemically dependent individual or family. The therapist whose self-esteem and sense of emotional safety depends on the client's restoration to wholeness is often intolerant of the lengthy and inevitable periods of fragmentation that precede recovery and will attempt to abbreviate or evade these painful phases. I have found that heroic therapists are particularly apt to block clients' expressions of hopelessness, panic and rage, since they (the therapists) associate these feelings with the onset of such frightening behaviors as relapse, suicide and physical abuse.

It is probably true that in the therapist's family of origin, the occurrence of painful affect did lead to these sorts of terrible outcomes; and it is very likely that when the therapist strives to prevent an explosion of feeling in the session, s/he is recapitulating a scene from childhood in which an understandable attempt was made to fulfill role expectations, to avoid feelings of failure, and to curtail parental destructiveness. While the abridgement of emotionality was an adaptive maneuver in childhood, however, it is likely to hinder, rather than facilitate, recovery when it is practiced by a therapist, and should be regarded as a member of the broad class of enabling behaviors. It may be helpful to consider some clinical vignettes that illustrate the unconscious suppression of explosive affect by a clinician and its deleterious effects on the course of therapy with chemically dependent and co-dependent clients. The first vignette describes my own painful experience with a highly self-destructive narcotics addict, while the second details a blockage in the work of a supervisee who was treating a suicidally depressed adult child.

Case 1: Jeremy

Jeremy was a 27-year-old man who had been addicted to prescription narcotics since the age of 18. The onset of his addiction was associated with his release from a state mental hospital where he had been a patient since the age of 16. Prior to his commitment to the state institution, Jeremy spent two years in a private psychiatric hospital. He was transferred to the state facility when his parents' insurance benefits were exhausted. Though Jeremy was a frequent runaway prior to age 14, there seems to have been no very good psychiatric reason for his institutionalization. He was a highly intelligent and resourceful youngster running from a sexually abusive father and an envious mother who held him up to constant ridicule and humiliation. His parents made the decision to hospitalize him when they decided to separate, and in retrospect, it seems as though they may have been scapegoating him for the failure of the family as well as seeking an alternative, low-cost solution to the problem of

child care and supervision. (Jeremy's younger sister was sent away to private school at the same time.) Jeremy's mother visited him once during the four years of his hospitalization; his father never visited him at all. Abandoned to, and suddenly dependent upon, the care of strangers, Jeremy was at first disconsolate. He cried much of the first week. At the end of the first week, however, he made a conscious decision to steel himself to all present and future terrors. He told himself, "I will not cry, and I will not be afraid." This bravado served him well in the hospital environment, where he became a MacMurphy-like character whose outrageous pranks relieved the tedium and quiet desperation of his mates. His toughness and ability to endure also enabled him to survive racial harrassment and violence in the state hospital and to successfully resist a mistaken attempt to subject him to electro-convulsive shock. No lamb to the slaughter he, Jeremy hurled a chair in front of the door to his room when told that he had been scheduled for electroconvulsive shock, and began to scream for his doctor. He continued to scream until the doctor arrived and corrected the wrongful order.

Though Jeremy survived the hospitals as well, if not better than many others might have, he walked away with a profound inner emptiness and deep sense of worthlessness based on the abandonment by his parents and his feeling that he must have done something to warrant the loss of their love. Heavily tranquilized during his four years of hospitalization, he also walked away with a deep dependency on mood-altering drugs. Jeremy expended enormous effort in his post-hospital life trying to overcome his fundamental distrust of others in order to build a relationship that might answer his sense of emptiness, but was plagued in his efforts by the "tragedy of fate" phenomenon: Each new love proved to be a compulsive abandoner somewhat worse than the last. Jeremy responded to each new experience of disappointment much as he had the first, with a determination not to grieve, and displays of bravado that, over the years, became increasingly antisocial and self-destructive. For example, his dependence on prescription narcotics and his supreme delight at conning a physician into writing an order for Tylenol #3 grew into a preoccupation with Dilaudid and eventually, heroin, and, he would feel compelled to haggle with, challenge and curse the biggest and most dangerous-looking street-corner pushers. He also began to shoplift, and to steal from his employer. The money that he made from these activities was sometimes used for drugs, but more often, given to friends. Jeremy's most frightening binges of drug abuse, aggression and thievery would occur on the heels of a disappointment from a woman. For this reason, my spirits would plunge when he would initiate one of these hopeless relationships. I would feel my own panic mount as he became increasingly rageful about each betrayal by his new lover, and as he began to consciouly contemplate, during his sessions, the prospect of a binge to relieve his inner turmoil. I deeply feared that Jeremy would

be arrested and imprisoned (which I thought might lead him to become suicidal), or that he would be beaten and left for dead by some pusher he had harrassed, or that he would overdose or perhaps inject air into his veins (a frequent fantasy when he held a syringe and needle in his hands). My fears were accompanied by feelings of helplessness and self-doubt concerning my ability to assist Jeremy. I usually responded to this complex of emotions with a flurry of activity. For example, I would concoct plans that would remove him from the immediate source of his unbearable feelings, by putting him out of touch with the woman who was troubling him. Jeremy had a most constructive friend who lived some miles out of town and was always glad to put him up for a few weeks, and who was well able to repair Jeremy's shattered self-esteem by the fact of his concern and care and through stern, "Dutch Uncle" discussions with Jeremy which made explicit reference to the considerable waste of intellect and talent which was occurring as a result of the drug abuse. I would refer Jeremy to his friend when my attempts to interpret his dilemma failed to quiet him, and if he refused to effect the "geographic solution" I would usually end up giving the Dutch Uncle talk myself, a considerable departure from my usual therapeutic attitude, which relies heavily on the restorative powers of empathy and the calm elucidation of inner conflict. When I found myself in the middle of the Dutch Uncle lecture, I understood that I was in trouble and within an inch of a discussion of hospitalization. While I am a strong advocate of rehab for most actively dependent individuals, Jeremy and I both intuitively understood that for him, hospitalization, or any kind of incarceration, would signify a capitulation to his parents' efforts to locate their illness in him, and close the sort of infinite loop of loss and disappointment that he seemed to be constructing. On the other hand, pointing to the impending closing of this loop, or noose perhaps, was occasionally effective in averting a binge. I loathed reaching this point with Jeremy, but I found myself there again and again.

Jeremy lived with his mother, and one night, in the middle of one of his most prolonged binges of chemical abuse, and after an extended period of emotional chaos between Jeremy and his latest lover, his mother challenged his self-destructive behavior in a manner that strikingly clarified the dynamic beneath my own ill-fated attempts to save Jeremy from himself and, coincidentally, suggested a rationale for his inability to save himself. It was around 2 a.m., and Jeremy had been on the phone, making plans to go downtown with a friend to purchase some heroin. Jeremy's mother listened to the call on an extension phone and before he could leave, ran into the living room and began to argue with him in an effort to dissuade him from leaving the apartment. The argument was heated and protacted, but it was clear that Jeremy was determined to go. When logic failed, when threats failed, Jeremy's exasperated mother grabbed a dinette chair

and threw it in front of the door in order to block his passage. Needless to say, this gesture was also in vain, but in Jeremy's account of his mother's behavior, I heard an echo, not just of my own fears, but of the desperation and panic he had felt in the hospitals, where he too, once threw a chair. I asked if he had felt scared about the plan to buy the heroin, and he replied that he had not. He had only felt angry at his mother for trying to stop him. I then told him that I had felt very frightened by his plans and his behaviors on several occasions, as his mother apparently did, and asked if he had ever felt this kind of deep fear about his own survival. Jeremy became thoughtful and spoke of two occasions which had so terrified him. The first involved an act of sexual abuse by his father, and the second, of course, was the time he had been threatened with electo-convulsive shock. He became very upset when speaking of these two incidents, his voice losing its customary tone of anger and defiance and becoming sad and small. I understood then, the continuing importance and impact of the vow Jeremy had made during his first week in the hospital, when he said, "I will not cry and I will not be afraid". He had banished his terrible fears and his deep emptiness in the certain knowledge that he could not afford them in the hostile environment of a psychiatric institution, and he was continuing to keep them at bay with the same brand of reckless and counterphobic daredeviltry that he had practiced back then. At the same time, his mother and I, like countless other co-dependents down through the ages, were caught up in his furious effort to avoid a confrontation with his deepest hurt. We are both children of alcoholics with an abiding, but misguided belief that the experience and expression of painful feelings must always lead to disaster for the ones we love and arouse feelings of shame and failure in ourselves. So, we protected Jeremy from his true feelings, by experiencing them for him. We felt the terror--the sense of impending disaster and irretrievable loss that he was determined not to feel or remember. We barred the door and tried to wrestle his compulsion to the mat so that, once again, he was able to take refuge in the anger and defiance that he had determined to substitute for feelings of terror and abandonment.

In order to alter this unproductive pattern, I had to recognize that in my own desperation to see Jeremy well and free of the awful feelings that fed his compulsion, I was coercing healthful solutions to self-destructive urges. Further, I had to accept that such solutions were temporary at best. At worst, they communicated a fear of the dark feelings that lay beneath these urges and a lack of faith in his ability to tolerate them and work them through. This deepened his sense of isolation as well as doing further damage to his self-esteem. I was able, eventually, to integrate this understanding into my work with Jeremy, and to continue to ask about his panic and his sadness with greater consistency and forcefulness. I was able to avoid

constructing alternatives to his binge behavior because, as he was able to describe and actually **feel** his terror of losing control, he was motivated to construct these solutions himself. I should add that this development was a long while in unfolding. He had been deeply opposed to exploring the feelings of panic and loss from the outset of therapy, and strongly resisted my attempt to amplify these themes in our work. However, my victory over my fear of his pain helped him to overcome his own.

I have also seen the will to restore affect the work of many of my consultees and supervisees who are the adult children of alcoholic parents. They, too, often seem compelled to stifle the expression of affect that must emerge in the course of a successful recovery.

> In one case, a COA supervisee treated an extremely depressed and masochistic middle-aged man who was himself the adult child of an alcoholic mother who had died from the complications of her disease. This client had made three unsuccessful attempts at suicide during his twenties and thirties, and when he entered therapy, was facing a combination of vocational, physical and familial problems that were rekindling these feelings of desperation. Though he was terrified of intimacy and had been socially isolated for years, he was able to respond to the concern and skilled intervention of my supervisee, and formed a strong bond with her. As his trust in her increased, he was able to share the depth of his despondency with her, and began to use his sessions to talk about his intense feelings of worthlessness and his wish to die. He also revealed that he had been stockpiling the sedatives that had been prescribed for his insomnia. These revelations represented an investment of profound faith in the therapist and were a mark of real progress in the work. However, the therapist, who had grown up with an alcoholic, depressed mother, was greatly disturbed by her client's feelings and blocked them at every turn. Abandoning empathy and cooperative exploration, she argued with her client as to whether his situation was truly hopeless; and though she had spent countless hours working with him to help him overcome his attitude of masochistic self-sacrifice toward his family, she now began to tell him he must give up the option of suicide in order to ensure their future well-being and happiness. The therapist was well aware that she had lost the empathic thread at this point, and she knew that she was conveying an attitude of disappointment and disapproval toward her client that only served served to heighten his feeling of failure. She felt compelled to

persist in this behavior, however, as if to smother his despair with her hope. Undoubtedly, this was a strategy learned in dealing with her own mother. When this therapist brought her dilemma to supervision, I would suggest that she fight her client's depression, not by beating it to death, but by re-establishing the empathic bond and thereby reducing his sense of isolation and rejection. I pointed out that he had good reason to feel terrible, and that it would be meaningful and uplifting to him if she could do what his parents had never been able to do--acknowledge and accept his pain and weather it with him. Of course, this therapist was well aware that despair must be expressed and shared before it can be resolved, but it was very hard for her to allow this phase of the therapy to unfold. Her compulsive will to restore her client to a state of balance and ease played havoc with her usually excellent clinical judgement and execution.

SUMMARY

Deutsch and Wurmser both argued that troubled individuals are doomed to recapitulate critical scenarios from their early lives until the conflicts that underly these scenarios are resolved. Winnicott (1958) also observed that people defend themselves against traumatic parental failures by freezing the failure situation, until it can be worked through, under more favorable circumstances, with healthier partners. Winnicott believed that psychotherapy should provide a healthful, adaptive environment in which conflict can be safely re-experienced, and he saw regression to a chaotic ego state as an important aspect of this healing process, especially in cases where early deprivation has been quite severe. The task of the therapist in these situations is to respond to the regression in such a way as to correct the parents' original failures. The alcoholic parent and his/her enabling spouse have usually failed in many ways, but the core problem may lie in the emotional habilitation of the children in the family. Raised in a condition of constant threat and subject

to intense and disturbing affects of every variety, the children of alcoholics are, nonetheless, taught to swallow their panic, their overwhelming sadness and their feelings of humiliation and despair. Their parents, engaged in a desperate struggle with demons of their own, have little time or inclination to listen or to soothe, or to say, "Tell me about it" and to work toward a resolution of frightening feelings. Furthermore, these children come to equate emotionality with the alcoholic parent's destructive outbursts and defend against the possibility of a similiar loss of control in themselves by repudiating intense feeling. Thus many children of alcoholics enter adulthood estranged from their own emotional reality as well as the empathic potential of human relationships. The therapist who seeks to correct these deficits must be able to stimulate--and then, tolerate--the re-emergence of the split off emotions, even though they may surface in their original chaotic form. These feelings will re-emerge as the therapeutic alliance develops, and the heroic therapist, with a deep commitment to the recovery of dependent and co-dependent clients, and with a profound understanding of the nature of their struggle, may easily inspire the confidence that is necessary to strengthen this alliance. The heroic therapist may falter however, as the alliance bears fruit and the client begins to experience and attempts to share, parts of the self that have been hidden and feared since early childhood. The heroic therapist also fears the destructive potential of intense emotion and guards against the irrational feeling of failure that would accompany an outburst of destructiveness by a client. Thus, he or she may hinder recovery

by employing the blocking maneuvers that were used to restore the false harmony of the alcoholic family of origin. The real goal of therapy is not to eliminace painful affect, but to foster a sense of psychic integrity and hope by allowing feelings of vulnerabilty to become conscious and accessible to the moderating influence of supportive human relationships. It is my belief that, in order to accomplish this goal, therapists who are also family heroes must closely examine their own reactions to the emergence of deep feeling and contend with the will to restore which may divert a good therapy from its healthful course and reproduce the inhibiting conditions of the alcoholic home.

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